PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 12
Date 1-28-2009
Bill No. SB [redacted] 233

Dear Committee Member:

I am writing with grave and serious concerns about SB 233 (psychology prescribing) just placed before the Montana legislature. I note similar proposals have been rejected in the past and wish to add my observations in opposition to this ill-advised legislation. I have been a practicing psychiatrist in Montana for 22 years specializing in psychopharmacology. I practiced in Billings for 4 years working in private practice with a part-time position at the Yellowstone County Mental Health Center and then with Deaconess Hospital as an inpatient and outpatient psychiatrist. I have worked with education in the Rocky Mountain College Physicians Assistant Program, as a preceptor for Advanced Practice Nurses (Nurse Practitioners), and given hundreds of lectures to various Physician (and other provider groups including psychologists) through the years. I was one of the first clinicians to use telemedicine extensively in the USA for psychiatric treatment. I currently work at the Montana State Hospital and am not writing in any official capacity but will say our medical staff and the Montana Psychiatric Association are very opposed to this idea. I would add that I have had many long and close relationships with my colleagues in psychology and have a great respect for them and the field of psychology. I always argue that therapy by a skilled therapist and medication is the best formula for most psychiatric conditions – and the data bear that out. Thank you in advance for your attention to my objections.

1.) The idea of 10 weeks (400 hours) of training for a psychologist to do what I and other psychiatrists do is somewhat insulting. I think many lay people do not understand the difference between the disciplines of psychiatry and psychology. After all both are called Doctor aren't they? This is mainly because up until the 1960's there really was not much difference. Psychiatrists were MDs who went on to study psychotherapy. Because they were MDs they could run hospital units and attend to physical problems. There were few medications available and these were often not very effective. The training in the 2 fields was very similar then, but is quite different now.

Through the 60's and into the 70's dramatic changes occurred with the development of techniques to study the brain, new medications, and a philosophic change (led by psychiatrists) to look at mental illness as a disease, much as diseases are approached in other medical specialties. Old concepts focusing on childhood were deemphasized and a more data based approach was formalized called the "Medical Model". This applied the thinking techniques taught in medical school – objective symptoms,

differential diagnosis, examination, history, and supporting testing before making diagnosis. The result has been the Diagnostic and Statistical Manual of Psychiatry. An imperfect document, but the standard of psychiatric diagnosis for many countries as well as the USA. In fact many "psychiatric" problems (schizophrenia for example) may now be regarded as neurologic conditions had these advances occurred at an earlier time. No serious mental illness is currently regarded to NOT have some underlying brain (usually chemical) problem.

Psychologists leave college with a degree but not necessarily a Bachelor's of Science. In fact it could be almost anything. Psychiatrists have to go to medical school and to be accepted to medical school a defined requirement of chemistry, organic chemistry, physical chemistry, mathematics including calculus, biology and physics must not only be completed but with high marks to be accepted into medical school. This is why so many pre-meds are so stressed out or "flunk out". These are difficult and highly competitive subjects – the grade "curve" is not easy. If you get a "C" in any one of the above you are not likely to get into medical school. There is no requirement for any of this foundation in science to get into psychology graduate school. Psychology itself is defined as a science by colleges but is often considered in a "pre-paradigm" phase or a pre-science if you will because of the lack of consensus in the field. Undergraduate psychology rarely deals with the brain as an organ or with the biochemistry of the brain.

In the first 2 years of medical school classes are 8 hours a day. A further year of biochemistry is required. In my school we reviewed the material from the college course in about 1 month and then went on from there. Other training pertinent to psychopharmacology was 1 year of physiology, genetics and embryology, 5 months of pharmacology, 5 months of psychiatry and sociology, and the neuroanatomy portions of 1 year of anatomy. All these subjects must be passed and a national test for mastery of these subjects must be passed for the student to continue on.

The 3rd and 4th years are referred to as clinical years. These are spent with practicing physicians in charge as well as interns and residents in the specialty. There are several mandated rotations students must complete including ob-gyn, internal medicine (twice),pediatrics, surgery, neurology, and of course psychiatry. Psychiatric patients are seen in almost all these experiences and the student learns how to integrate the various specialties, the functions of a hospital, the functions and relationships with other professionals including the pharmacy, diagnostic examination and thinking,

and the responsibilities of patient care. Satisfactory completion of the courses and passing another national test is again required to continue on.

At this point a psychologist is ready to leave school and begin seeing real patients without supervision. Now some psychologists take longer to complete the 4 year training program just as some MD's can decide to take longer to finish medical school.

A year of internship must be completed. With a special training license the intern sees patients and prescribes but with supervision of each patient and every order they write. For psychiatry internships internal medicine, neurology, intensive care or cardiology, pediatrics, as well as psychiatry are encouraged if not mandated by their residency. These are very busy days – often more then 60 hours a week not including being on-call. Laws have been passed to try to reduce these hours but they are invaluable in some ways for learning to handle future demands. Again a national test must be passed to go on.

Finally psychiatry residency begins. The main feature here is 3 years of patient care responsibilities with progressively less supervision. Included are outpatient, inpatient community hospital, nursing home, child and adolescent, emergency room, addiction, medical consultation and long term hospital experience. Psychotherapy and behavioral therapies are taught and used in all these experiences (often by psychologists) but psychopharmacology is the main focus. Psychopharmacology is presented in a defined curriculum approved by the National Residency organizations and the specialty boards. Not classroom alone but active practice with real patients while in classes that provides for much improved comprehension and retention of the material. Supervision is not just talking to someone about the patient but frequently observed interviews either by the trainee or supervisor and discussion including the patient of treatment. Learning to use and manage hospitalization is very important in a field dealing with life-threatening illness and being trained to make those decisions and making them is crucial for our patients.

Now our psychiatrist is ready to treat people on his own. The psychologist as been doing this for 4 years – no doubt complying with continuing education requirements. The psychologist may or may not have ever taken a college chemistry (much less graduate level) class. The psychologist has never personally admitted or managed even 1 patient in a hospital. The psychologist may or may not have worked in a state hospital. The psychologist never ordered or likely even seen any lab test or brain imaging. But the psychologist thinks after a 10 week class of some design and vague "supervision" by someone of 100 patients with some kind of

mental illness is ready to treat the same spectrum of problems with potent new tools as the psychiatrist who specifically trained for the job.

Please let me review some other issues:

2.) Lacking any systematic training in medical disease and medications used in other fields psychologists are not prepared and I would argue not competent to form a differential diagnosis that includes "medical mimics" of whether this is really a psychiatric diagnosis. They are very capable in determining what diagnosis it is when the condition is found to be psychiatric. These "medical mimics"can be dangerous situations involving life threatening conditions often in our most fragile populations – the elderly, the neglected health of "street people", the risk taking and self neglecting substance abusers, and children. Currently psychologists have to work in tandem with physicians on these issues. I would argue that giving them a prescription pad removes the necessity for an important part of the evaluation process. Every patient who receives a psychotropic medication should have a physical exam (at least good medical history documented) and baseline laboratory studies. Is this also part of the 10 weeks of classes? It takes considerably longer than that for MDs to master this and more than just reading a checklist to do competently. Lacking the required education how does the prescribing psychologist know what to follow up on or order further clinical studies on. Refer to an MD? – aren't they saying the MDs are too busy now and that's a reason they should be able to prescribe?

2 weeks ago I received an admission with a PhD psychologist as a professional person. He determined the patient was psychotic based on thinking he was somewhere other then in the hospital and thinking his girlfriend was his daughter. The patient was in intensive care and had had renal problems, pneumonia, seizures, and was on a high dose of pain medication. The patient was given no medication after transfer to my unit other then a lower dose of pain medication and was completely clear and home in 4 days. This patient had a delirium and because he was discharged by the court (by law) we don't know what happened and the patients family has to scramble to get outpatient help as he's had 2 other episodes of this (I've talked with them several times on the phone since his discharge). The MDs in the hospital had the correct diagnosis (delirium) but lacking the education the psychologist called it psychosis – it's scary to think he might have been able to prescribe to this man.

3.) Psychologists do not have hospital admitting privileges. In fact they usually have no relationship with hospitals at all. Some have spent little time in the hospital environment in their training and career – we don't know as it's not standardized. That means that seriously mentally ill patients or

patients in crisis will be "dumped" on already overburdened hospital ERs and psychiatrists. Medication side effect crises will have to be handled by the clinicians who oppose allowing psychologists to prescribe. In other words we're going to have to fix their mistakes. An example is manic symptoms that can be induced by antidepressants. It serves as a learning experience for the clinician when this happens and changing clinicians at this time is difficult at best especially for the patient.
We have had a few issues with this with psychiatrists and the Montana Board of Medicine has told us we can't do anything about it with them – adding a whole new practice group to this is overwhelming. So it can be hard enough to get psychiatrists to take responsibility for their patients care – why add a group that can't. If you can't clean up your own mess then don't make it in the first place – that is a good limitation in any field of medicine as well as life.

4.) I contend that psychologists are not well prepared for covering their practice 24 x 7 and being on-call which I think is essential (and so do the lawyers) for good medical care. Many psychologists have answering machines that say "I'm not available, go to the ER" I figure now that's inconvenient for me but they'd probably come anyway. Adding medication related problems to this is unfair and dangerous. (Certainly many psychologists do have good practice coverage).

5.) I think psychologists would have a valid objection if we allowed an MD to take a 10 week course and have 100 "supervised" cases (by who?, what's "supervision", what cases?) and then call themselves psychotherapists. I would support their objections to that scenario.

6.) This is an era of controversy regarding psychiatric medications and more often the side effects of these medications. Billions of dollars every year are on the line in court in litigation. These include cardiac issues, weight gain, diabetes, bleeding disorders, stroke risks, movement disorders, drug-drug interactions, liver problems, kidney problems and seizures, just to name a few. Is it really in the best interests of Montana's citizens to "dumb down" the quality of care in the name of access?

Psychiatric medications are described in the pharmacy literature as the second most dangerous class of drugs after anti-cancer drugs. They are potent medications and deserve the respect from our legislature that they are given by pharmacists and the courts.

Studies show less than 50% of patients who are treated with antidepressants stay on that particular medication. A lot of the changes are not about lack of benefit; rather it is about side-effects. Skilled clinicians often know what to avoid in the first place as unlikely to be tolerated and

which is most likely to produce the best response. Much of this is based on detailed knowledge of brain chemistry and other organ systems as well. That's knowledge you only gain competency with after 4 years of studying it – in other words medical school.

Some may say "well, we can look these things up when we need them". I would respond that it's hard to do that if one is not sufficiently aware of the possibility of a problem. 10 weeks of class does not provide that level of familiarity. The 100 "supervised" patients are 20 less than I admitted to hospital personally in the first 4 months of my residency.

Let's try an analogy – flying is risky. Pilots go to school and learn to fly as a private pilot. There is a certain level of competency to become a private instructor and a private pilot. Handling emergencies in a small plane is one of those tasks. After completing this a pilot is allowed to fly with restrictions. Compare this to a commercial pilot – now the lives of others are at stake. The instructors have to have much more training and the pilots have to manage much more complicated machines. My friends who are commercial pilots tell me the machines are actually easier to fly – the issues they train for are about safety. The majority of their training is what to do if something goes wrong, how to know what's going wrong, to recognize something bad is happening, and to practice what to do if that something is happening – to have already experienced it.

We could use the "I can look it up" response to many things in medicine but to most of us that is not sufficient for competency. We could even argue for people doing their own appendectomies at home – all the information is on the internet after all. If the Pilots of commercial planes had to look everything up when there was a problem or to even know if there was a problem the skies would be empty soon.

I believe that when psychologists think of prescribing they're thinking of that "easy" prozac case in the healthy 23 year old. But that is not the real world. How about the healthy 22 year old who was on prozac and got manic and spent 6 weeks in the hospital? Or the 24 year old who developed liver disease on prozac? There is a reason why the FDA has not approved these medications for over-the counter use.

7.) This Bill purports to be about access (I contend it's really about egos but I digress). We have enough providers to handle these "easy" cases that I believe is the psychologists' fantasy. Primary care physicians have the training to prescribe and monitor side effects of medications. It fits well into the comprehensive care of the patient in other areas including prevention interventions. They have the connections to get help when they are getting concerned and know when they're getting over their head. Physician

Assistants can prescribe but under the supervision of their sponsoring physician. Advanced Nurse Practitioners can prescribe within the domains of primary care or psychiatry. They are almost always affiliated with a physician or psychiatrist but do not have to be. They require 2 years of training with supervision in addition to their nursing degree. I admit it can make me nervous when these ancillary providers are too independent or dealing with complex psychiatric or medical-psychiatric problems but again the medical training and relationships usually gives them connections to get help. Saying that since this we've taken the risk in these situations makes it a good idea or even an ok idea to add another (riskier) group to the mix is saying 2 wrongs make a right.

I argue that most psychologists do not live in small town Montana – but rather like the psychiatrists tend to the larger population areas close to higher levels of medical care. Telemedicine can and has the potential to further expand psychiatric care to these areas.

The issue is not access for the average Montanan with depression as much as it is about the care of the chronically mentally ill who are on 2 or 3 or 4 psychiatric medications along with other health problems. These are the patients who would be least served by this proposal and the most harmed.

8.) Let's talk politics. This proposal has been rejected before and its proponents are clearly trying to wait for someone's guard to be down to sneak it through – this was also the tactic used in Louisiana. Although that was a very last minute approach so I should appreciate this was a little more upfront than that situation. But doesn't that tell us something about the merits of the proposal?

I believe it should say something that NO approach regarding this has been made to the Montana Psychiatric Association. Not even an attempt to discuss it. NO approach has been made to pharmacists in the State of Montana. The only significant effort has been legislative.

The Bill itself is so vague as to be frightening. The Psychology Board who has no competency or experience with pharmacology is going to approve a program? How do they do this? We need (and deserve) specifics on this issue and as best I can see the people who are going to set the training up have never had the training! Or any level of competency in this practice. Who does the discipline and reviews for prescribing pharmacists? A board composed of people (maybe 1 or 2 would be on the board who prescribe) who have had no training at all in the field?

The term "supervision" is used so loosely that it has no meaning. Are we talking about a sit-down review with the patient and the chart with the supervisor at every visit – that's supervision for beginning psychiatry

residents – or a brief phone call with an "expert" out of state? Who are the supervisors? We all know now that Montana psychiatrists oppose this. The answer I get from this Bill is "Trust us – we've never done it before but we'll figure out what to do" Ladies and gentlemen that is not sufficient to safeguard the health of Montanans.

9.) This proposal has no limits to age or drugs covered. Are we going to allow psychologists to prescribe for children? This is one of the most heated debates in the medical literature and the lay media. Even fully trained and experienced adult psychiatrists are reluctant to go here. How about the elderly? The new generation antipsychotics have a Black-box warning regarding use in the elderly – the strongest possible FDA warning while still keeping a drug on the market- regarding increased risk of death. How about schedule 2 drugs (high abuse potential)? Psychiatrists do prescribe narcotics on occasion – should we start allowing less trained precribers to do this? Dextroamphetamine and Ritalin? Usually for kids and highly abusable and highly diverted for non-medical uses. Should we allow another group prescribing benzodiazepines (valium) with their addiction potential and dangerous withdrawls?

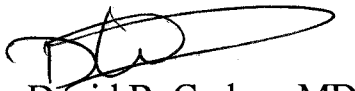
10.) I would point out that psychology school is just that – training in psychology. I do not hold myself out to be a psychologist although that was one of my majors in college. When a person goes to psychology school they know what they are training to do. As I said before I have always valued my relationships with my colleagues in psychology. I work closely with a psychologist on my unit at the Montana State Hospital and value her contributions to our patient's care. They bring a perspective that is crucial to the recovery of people with mental illness. They are often closer to the patient: have seen the patient longer and more often. But they know little about medical disease, the biology of the brain, pharmacology in general, and crucial other organ systems involved in psychopharmacology – and certainly not at the doctoral level. This proposal trivializes the training and experience needed to safely deal with patient care. It suggests that it is as easy to learn antipsychotic treatments as it is prozac.

No one is barring a psychologist from prescribing – all the psychologist has to do is get into medical school (probably have to go back to college to get all the science I mentioned earlier) and finish a residency. It doesn't even have to be a psychiatry residency. Learn to the degree the law has mandated prescribers need to be educated to. Or get into a Physician Assistant program (again most will have to go back to some college) and work with a physician. But this Bill is not about that. There are the reasons noted above why psychiatry requires an MD and why 4 further years are

required to be considered competent. If a psychiatry trainee said "I'm just going to go to classes and study talk therapy and theory for 4 years and then take a 10 week class with 100 "supervised" patients and then graduate. . ." Well, that would not happen – we would all agree that is ridiculous, but here it is in front of us in a slightly different form. This Bill mocks the science, the risks, and the importance of psychiatric medications.

11.) This proposal will hurt efforts to get more psychiatrists to Montana. We already have seen hesitation after the misguided approval of similar legislation in the couple states that have approved similar proposals. Psychiatrists do not want to go somewhere to clean up other clinician's mistakes. This does not help mental health care in Montana. The lack of support from other groups suggests to me they do not perceive any benefit from this legislation, but do not want to alienate the psychologists. It does not help the patients who really have the issues getting access to care – the more complicated cases who often are Medicare or Medicaid. I think in the end this is a result of psychologists fantasizing about that easy patient and trying to get a bigger share of the health care dollar. Well – it's your dollar and I ask you do you spend it on someone with 10 weeks of class and 100 patients or chose someone with 8 years of schooling and several hundred patients? Thank you again for your attention.

Sincerely,



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